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5. Thought

Like craniotomy, the assessment of thought calls for knowledge and experience and technical skill. While other health and social services workers (police, clergy, surgeons) can give a fair account of some aspects of the mental state of a patient, it is only with special training that thought can be fully assessed. Abnormalities in thought are powerful diagnostic pointers.

Two aspects of thinking are examined:

- form (the connections between bits of information)
- content (what the individual is thinking about)

By convention, under form of thought disorders (FTDs), in addition to kinds of primary FTD, are included two kinds which may be alternatively conceptualized as primary rate of thought disorder: flight of ideas and poverty of thought.

Thought is largely assessed by the examination of speech. To the extent that what is said may not precisely reflect what is thought, care must be taken.

Thought is also reflected in behavior. A person who places a sign on his/her front door warning that aliens have landed and barricades him/her-self inside with lethal weapons, would appear to be suffering from a disorder of the content of thought (DCT). Behavior gives less clear evidence of FTD, for although impaired thinking leads to impaired planning and ultimately, unsatisfactory outcomes (i.e., failure to secure employment), behavior also depends on a range of additional factors including personality, motivation and cognitive abilities (reduced, for example, in head injury and dementia).

On occasions, behavior may predict with considerable certainty, FTD. (Figure 23.)

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Figure 23. A carpenter was admitted to hospital with form of thought disorder of and disorganized behavior. In the Occupational Therapy Department he set about making a cross (Christian) to hang on his wall at home. Rather than fix together two pieces of wood symmetrically and at right angles, he nailed two pieces of wood together such that the left and right arms were different lengths, and the angles they made with the upright were not right angles. To correct the different arm lengths, he roughly nailed additional pieces of wood to them. This increased the weight of the arms and made the central join unstable. To increase stability, he then nailed pieces of wood between the points of cross, thus producing a uneven quadrangle with a cross in the middle. The patient's parents were worried by the quality of this work and stated that it was much below the patient's usual standard. When the patient recovered he was embarrassed by his cross and could not explain his poor workmanship.

Clinicians are assisted in making decisions about the presence/absence and type of FTD, by clear definitions and the smallest possible number of categories which will accommodate all examples.

This field has become complicated as authors have proposed ever more changes and additions. Berrios (1996) states 'After the First World War,

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papers carrying the words 'language' or 'thought' disorder in schizophrenia began to appear: in the 1930s the trickle had become a flood...'.

The current author proposes using established definitions, but leaving out some categories (i.e., 'knight's move thinking', 'condensation' and 'tangentiality') to reduce the number of choices. The clinician needs to know half a dozen types of FTD to master the area. It may be useful to know of other definitions for academic purposes, but they are not needed in clinical practice.

Form

Form means the 'arrangement of parts' (Oxford Dictionary). FTDs are disturbances in the logical process of thought - more simply, disturbances in the logical connections between ideas.

FTDs are as diagnostically important to the psychiatrist as stumbling when walking is to the neurologist. Both can represent significant brain dysfunction.

Clinicians must be vigilant to detect FTDs, and cautious not to classify non-pathological thought as FTD.

In everyday life we pay attention to the content of our conversations with friends and colleagues, paying particular attention 'the bottom line'. We tend to ignore the 'noise' of changes of subject and direction. Because we know the culture, "we know what they mean".

The learning clinician is encouraged to listen to the form of thought of 'normal' conversations, firstly to hone skills, and secondly, to become familiar with the 'normal range'.

Clinically, the form of thought is assessed throughout the initial interview, and at all subsequent contacts. If the interview is a highly structured series of questions and answers, disorder of the form of thought will be less obvious. Accordingly, the examiner may arrange opportunities for the form of thought to be more closely examined - this means periods with little structure, when patients are encouraged to speak freely and required to impose their own structure. Opportunities include:

- asking open ended questions of any sort – "What are your plans for the future?" Here the examiner has not mentioned study, work,

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- residence, social activity, hobbies, travel, so the patient – the patient may ask, “In respect to what?” To which the examiner might continue in the non-directive manner, “Oh, I don’t know, in general, I guess.” – and see what happens.
- asking for explanations, as mentioned in the introduction. “Why did you come to hospital?” and not interrupting by asking for clarification before the patient has finished. “Why do you think your family brought you to hospital?”, and if the patient states the family were mistaken, “But, why would they think that?” When there are hallucinations or delusions, one can ask for explanation, “I have to tell you, I can’t really hear any voices myself. How can that be?”
 - asking religious/philosophical and futuristic questions. These can be tailored to the patient. If patients have talked about having faith, it is reasonable to ask, ‘Why do you believe in God?’. If patients have talked about outer space or scientific theories, it is reasonable to ask, ‘How could time travel contribute to pollution?’ or, ‘What would the relationship be between the space creatures you have described and the Christian God?’
 - asking the meaning of proverbs, such as, ‘A stitch in time’, ‘People who live in glass houses’ and ‘Still waters run deep’. Naturally, it is important to take into account the intelligence, education and cultural background of the individual. Those with relatively low intelligence and little education are likely to give less sophisticated answers.
 - ask nothing. Sit in silence with the patient for a short time, the patient may break the silence with a disordered comment. Silence is uncommon in everyday, conversation and can be threatening. This technique is of limited use, but may suit some patients.

An example of an abstract/open ended question (Solovay et al., 1986):

Interviewer: “Why should we pay taxes?”.

Patient: “Taxation, we have representation...taxation without representation is treason ...”

Here we find the loss of logical connections between ideas, and so, FTD.

Further, treason is usually clandestine and dangerous - the sort of issue that worries patients who are unduly suspicious or have persecutory delusions.

Thus, the mention of treason in a routine doctor-patient interview suggest that the patient may also have a disorder of content of thought. An

abstract/open ended follow-up question might be, “You mentioned treason, just then. Why do you think treason happens?”

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For technical reasons, if present, it is essential to record some verbatim examples of FTDs in the patient's file/notes. While dramatic or humorous thought disorder may be remembered for a few minutes, the more common, less remarkable examples, the simple slipping off topic during conversation, which carry the same diagnostic power, are difficult to remember. This is partly because we remember logical sequences more easily than random information, and partly because, in the presence of FTD we have to concentrate closely on proceedings, making the keeping of mental notes more difficult. It is recommended, the clinician write down verbatim extracts as the patient speaks, either directly into the file, or on other paper from which they can later be transcribed.

Derailment

Derailment occurs when a train jumps off the track. Kaplan and Saddock (1991) define derailment as gradual or sudden deviation in the train of thought.

Andreasen (1979) defines derailment as 'A pattern of...speech in which the ideas slip off the track onto another one which is clearly but obliquely related, or onto one which is completely unrelated'.(Figures 24-27.)

The term derailment was introduced to replace the earlier term, 'loosening of associations', which had been introduced by Eugene Bleuler in 1911. (He believed that looseness of associations was the fundamental abnormality of schizophrenia, from which all other symptoms emanated. He also introduced the term 'schizophrenia').

Authorities promoted use of the term derailment, because the term loosening of associations had been used indiscriminately, and had thereby lost meaning.

Kaplan & Saddock (1991) state that derailment and looseness of associations are "sometimes used synonymously". Separate definitions may still be found, but it is strongly recommended that only the term derailment be used.

Tangentiality was once equivalent to derailment, but was redefined by Andreasen (1979) to apply only to answers, not to spontaneous speech. For example:

Interviewer: "What did you have for breakfast?"

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Patient: "They grow lovely pineapples in Queensland".

Tangentiality is a separate FTD is certain research instruments, but the current author does not recommend the distinction in clinical practice.

Among the most disabling consequences of schizophrenia is the inability to budget, plan and carry out family, social and business activities. FTD is at least a major contributor to these impaired functions.

Derailment may go unnoticed or passed off as an eccentricity of expression, by the man in the street and the unwary clinician, but it represents brain dysfunction and may indicate a potential or extant devastating disorder.

Tony - To Whom it may concern!
 I feel that while I'm in PICU
 my rights (re smoking) are
 completely and utterly taken
 away. This is not fair under
 the Australian national anthem,

Figure 24. Letter was written by a young man in a Psychiatric Intensive Care Unit (PICU) in which smoking was not allowed. He wrote to the Nurse in Charge (Anthony Weare), commencing, "Tony". He next wrote "To whom it may concern". This is an unusual way of commencing a letter. The patient man was writing an official letter of complaint, and the impression is that after writing the relatively informal, "Tony", he derailed onto a more formal, impersonal style. He complains about not being allowed to smoke and ends by this "is not fair under the Australian national anthem". It is assumed he wanted to claim this restriction was against Australian law or the Constitution, or similar formal body, but wrote "anthem". Anthem is a word with formal and national applications, but does not fit with this

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particular message. The reader may think much is being made of nothing, but this is offered as an example of minor derailment.

Dear Grand-niece
 Hope you are reading
 through the Women's Weekly and
 enjoying it.
 We have a lot of them up here
 with Lida in them.
 Have you anything wrong with
 you?
 Mummy and Grandma and Great
 Aunt love a lot for you which
 knows no bounds.

Figure 25. This letter was written by a woman with schizophrenia who was living in a long term psychiatric hospital to her Grand-niece. It was subsequently handed to the current author because of concern about what was meant. The patient begins by hoping the child is reading the Woman's Weekly, and this section ends with an expression of great affection. The line which caused concern was, "Do you have anything wrong with you?" In the opinion of the current author this is a mild derailment, it is believed she meant, "I hope you are well".

I think my family + relatives reject me
 because you are a psychiatrist.

Figure 26. This note was given to the current author by a young man who claimed his family and relatives rejected him because he was seeing "a psychiatrist". There was no evidence of his family and relatives rejecting him – this may have been either a delusion or a wrong conclusion by a distressed person. It is believed this man meant to say he was rejected because he had

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a severe mental disorder, but derailed and stated the rejection was because he was seeing a psychiatrist. (The patient may have been correct, but derailment seems more likely.)

I would like to see
Schizophrenia not used as a
diagnose but instead allow
full integrity or $\frac{1}{2}$ integrity
by calling it

(1) insomnia after admission.

(2) ~~One~~

A poem with one way
signs to stop ankle wear
and tear.

Figure 27. This note was written by an unknown person and retrieved by the current author from a rubbish bin. There is lack of insight – in the first 3 lines the individual is contesting the concept of schizophrenia. He/she spends 2 lines on the topic of ‘integrity’ – perhaps describing a psychotic experience, or a desire to be valued as a complete person. He/she then suggests that schizophrenia might be called “insomnia after admission”. This argument is poorly presented, suggesting thought disorder. The last 3 lines provide unmistakable derailment – the topic is what schizophrenia should be called, “a poem with one way signs to stop ankle wear and tear” is a complete change in direction and makes no sense.

Derailement is rarely complained of by the patient. There are few reports of patients complaining of the subjective experience of FTD of schizophrenia. This may be because the suggestion one is not thinking properly is highly threatening to our sense of self and autonomy, and with impaired theory of mind (the ability to be aware of the independent mental life of others) most patients are simply not aware that others are often unable to follow what they are saying. (Figures 28.)

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Isolated examples of derailment may occur in the conversations of healthy individuals. It is, however, a classic marker of schizophrenia (particularly in subtypes with younger onset). It is also found in schizotypal personality disorder, mania (see later, under flight of ideas) and depression. It may also be necessary to exclude the dysphasias (of vascular, traumatic, degenerative or other organic origin).

I've been told I'm schizophrenic
 but I don't think I am
 the only feelings I have are
 confusion, plus weather I look normal
 I feel as if I'm being punished for a crime
 I didn't commit
 Actually I don't know ^{who} to blame at times
 My thoughts seem to linger into each other
 therefore I get completely confused.
 I feel so lost and lonely
 I once heard a phrase which went, "Who can
 you tell if you haven't got a friend?"
 which I am feeling very strongly ^{about} so I decide
 -a, to write it on a paper
 So someone, anyone! could you listen
 and give me an explanation.
 Or even maybe help sort out my confused
 state of mind.
 I don't want to take heaps of tablets
 I want a truthful explanation of my feelings
 so that once and for all I can
 understand my mind, and why it is constantly
 confused.

Figure 28. This letter was written to the author by a young woman suffering schizophrenia. Two years later she died by suicide. (It is worth reassuring the reader that she was given extensive psychiatric and social care.) Her letter contains a host of psychopathology including form of thought disorder, persecutory thinking and lack of insight. It is presented here as an uncommon example of the subjective experience of formal thought disorder.

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She states “The only feelings I have are confusion”, “My thoughts seem to linger into each other therefore I get confused” and that she wants an explanation so that she “can understand my mind, and why it is constantly confused”. For her, the subjective experience of formal thought disorder was the most distressing (threatening) aspect of the disorder.

Flight of ideas (includes clanging)

In flight of ideas, rapid, continuous verbalizations are associated with constant shifting from one idea to another. It should be reserved for clinical situations where pressure of thought is present. “Flight of ideas is a derailment that occurs rapidly in the context of pressured speech.” (Andreasen, 1979) (Figures 29-32.)

The difference between derailment and flight of ideas is sometimes difficult to make. But, making a diagnosis of a mental depends on many observations, and it is unlikely that a diagnosis will depend on this single differentiation.

When the verbalizations of people with derailment and flight of ideas are transcribed into writing, unless the person with flight of ideas is making jokes and clanging/rhyming, the reader is unable to tell them apart. There is the same sort of going off track in both. In the current author’s opinion, in derailment this can be viewed as slipping off track (there is something wrong with the wheels or the track), in flight of ideas it is as if ideas are pushed off track from behind. That is, flight of ideas depends on there being pressure of thought (speech is rapid, louder than normal and difficult to interrupt).

Wing *et al.* (1974) describe three types: 1) where there is rhyming, alliteration or clanging, e.g., “ill, illegitimate, illusion”; 2) where there is an association by meaning, including opposites, e.g., “white, black, coffin”; and 3) where there is distraction, e.g., a patient talking about his appetite sees another patient walk past the window, assumes that patient is going for ECT and starts talking about ECT.

In the current author’s opinion, all of these are forms of distraction. In rhyming/alliteration, the individual is distracted away from the message they were intending to send (staying on a particular track) by the sound of the word they have just uttered/thought, in the second example it is the meaning of that word which causes the distraction, and in the third example it is external events which causes the distraction.

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Clanging is often encountered in flight of ideas – basically it means the association of words on the basis of sound. It is essentially interchangeable with rhyme. Some claim that rhyme is concerned with the sound at the end of words, and alliteration is concerned with the sound of the beginning of the word (“ill, illegitimate, illusion”). But this is a fruitless discussion and ‘clanging’ and ‘rhyming speech’ can both be applied to both traditional rhyme and alliteration when describing this type of flight of ideas.

Andreasen has also drawn attention to punning. In an early draft of her Thought, Language and Communication Scale, she gave the example, “I’m not trying to make noise...I’m not trying to make sense (cents) anymore. I’m trying to make dollars”. Here the sound of the word ‘sense’ brings in a new topic, which is the essence of punning. In flight of ideas, punning does not need to be placed in a category separate from clang/clang. Not surprisingly, with high mood elevation the punning of flight of ideas can be frequent, amusing and apparently clever.

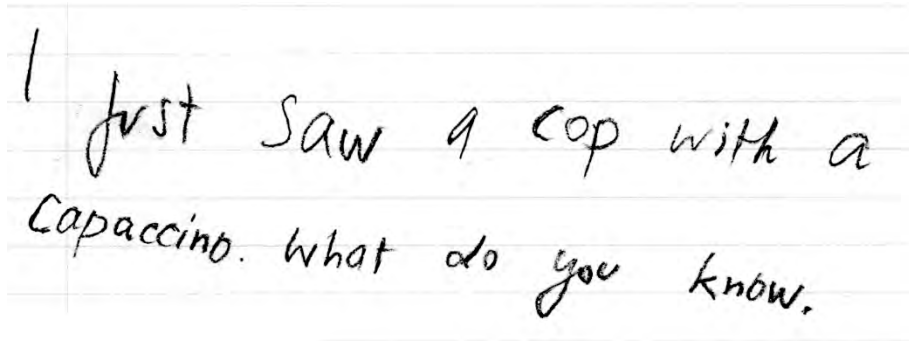
Flight of ideas most often occurs in mania, however it also occurs in schizophrenia. Intoxication with stimulants must be excluded. Curiously, with infarction of the cerebellum, the patient was loud, disinhibited and manifesting what could pass as flight of ideas.

Dr Fridmore gives a damn
 He's a real doctor not a sham
 Men are funny but you get that
 I reckon he'd look cool in a
 houndstooth hat

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Figure 29. This note was written by a woman suffering mania. There is light hearted humor, but the point of interest is the clanging/rhyming



I just saw a cop with a
Capuccino. What do you know.

Figure 30. This note was written by a young man during an acute manic episode. He was overactive. He would leave the hospital and go walking in the city . On his return he would leave messages at office of the current author. Seeing a policeman drinking coffee is an trivial event and would not usually be considered worth reporting. That he did so suggests pressure of thought. It is interesting that in these two short lines there are examples of two forms of clanging. The syllables 'cop' and 'cap' constitute and alliteration. The words at the ends of these sentences 'cappuccino' and 'know' rhyme. The sentence 'What do you know' adds no new information and is vehicle for playful rhyme.

Up and Down like
a very rough sea.

Psycho - (log - i - cal
 | eye ca?love
 a
 |
 rhythm

raising the
number
or
anchor at
last from 0 to smooth
 sailing.

Am I psycho or logical
was the question I
could not answer.
Now I hope I'm logical

Figure 31. This note was composed by a young person suffering mania. A central feature is the word Psychological. The association of psychological and logarithm is an example of clanging. A possible explanation of some other features may include that the word logarithm suggested 'raising the number' which then suggested raising an anchor. This may have brought to mind the idea of 'smooth sailing' which may have suggested the 'up and down like a very rough sea'. This addition may also have been suggested by the idea of raising the anchor, and the up and down cycling of her bipolar disorder.

She added 'Am I psycho or logical'. At the time this was written, in popular parlance, the term 'psycho' meant mentally ill. She finished with the hope that she is logical. The tone of the note is light-hearted, and the fact that she "hopes" she is now "logical" suggests some insight, that had/has a problem.



Figure 32. This drawing a caption was made by a young science graduate who suffered mania. A number of features suggest mania. The drawings are colorful and hurried. The rhyme, while masquerading as rhyming poetry may also be classed as clanging. The information is poorly communicated. While white may reflect or throw back light, to say that it throws ‘out’ light (akin to radiation, perhaps) is misleading, and not what would be expected from a fully functioning science graduate.

Patients do not usually subjectively distressed by flight of ideas, although they frequently acknowledge that they sometimes stray off the point – in which case they may be frustrated by those who can’t “keep up” with them. (Figure 33.)

There's a finish line at the back of the jetty where
 those navel oranges grow.
 upside down video clips of emus talking to foxes.
 I see vegetables growing and those carrots have a lot
 of venom. Keep still or they'll spot you and kill you.
 I'm going mad. Stop this dribble. Fuck Fuck
 Write them as they come bitch baby.
 Don't mess with your mind Ring your 6
 or that mobile because you're going to die
 upside down. Carry this with you or your
 toes will drop off Bing. like rollerblading on
 a Strawberry Patch round & round.

Figure 33. these lines were written by a young woman during a manic phase. There is marked flight of ideas, and this illustration might also have been placed under poverty of content. The reader senses the pressure, and we are only getting 'grabs' of thought ("Write them down as they come bitch baby"). It is presented because of the fourth line, "I'm going mad. Stop this dribble (probably meant drivel). Fuck Fuck. Thus, we can assume the subjective experience of this thinking was unpleasant.

Poverty of content

Poverty of content is a more severe form of FTD than derailment/flight of ideas, but the processes may be the same. For the clinician to be able to form an opinion about the presence/absence of poverty of content, the patient needs to provide sufficient words (or actions). (Figures 34-38.)

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In general, people with poverty of content talk fairly easily, and they usually retain our interest for some time. Various mechanism (which may be combined) have been observed:

- The individual always seem to be “just about to make a point”, but somehow, they “never seem to get there”.
- The individual raises a series of questions. When about to address one of these, he/she raises another.
- Excessively concrete thinking, or alternatively, excessively abstract thinking.

2.

FROM GOVERNMENTAL AND BUREAUCRATIC SOURCES OF ADMINISTRATION
AND DIRECT DEPARTMENTAL CONTROL.
IN AS MUCH WE MAY REGARD THIS FORM OF CONTROL
AS CLOSELY ALLIED TO ~~AN~~ UNDEMOCRATIC CONTROL,
OUTSIDE THE "PROVINCE" OF THE DEMOCRACIES.
EVEN TODAY DEMOCRACIES HAVE MADE ALLOWANCE
FOR THE USE OF SPECIAL EMERGENCY REGULATIONS AND
STATUTES OF PARLIAMENT TO BE DIRECTED ~~WITH~~
~~ARE~~ TO LOCATIONS OF "SPECIAL EMERGENCY" IF AND WHEN
IT IS ^{SHOWN} ~~SHOWN~~ DESIRABLE THAT A SPECIFIC ^{COURSE} ~~COURSE~~ OF ACTION
IS CONSIDERED DESIRABLE IN THE BEST INTERESTS
OF A POPULATION OF PEOPLE CONCERNED WITH
PRESERVING ^{THEIR} GIVEN TASTES, IDEAS AND CAPACITY
TO MAINTAIN GIVEN CULTURAL, EDUCATIONAL AND SCIENTIFIC
APPETITES OF A POPULATION.
IT IS ALWAYS THE CASE OF GIVE AND TAKE!!!

Figure 34. This "essay" was written by a well educated middle-aged man who was living in a psychiatric hospital in the 1970s. At that time his writing was incoherent. He provided the current author with examples (about 600 pages) of his work from a decade earlier. The earlier work was 'easier to follow'. This page (from his earlier work) begins with "From Governmental and Bureaucratic Sources of Administration and Direct Departmental Control". It continues with mentions of "Democracies", "Populations", "Cultural, Education and Scientific" and ends with "Its

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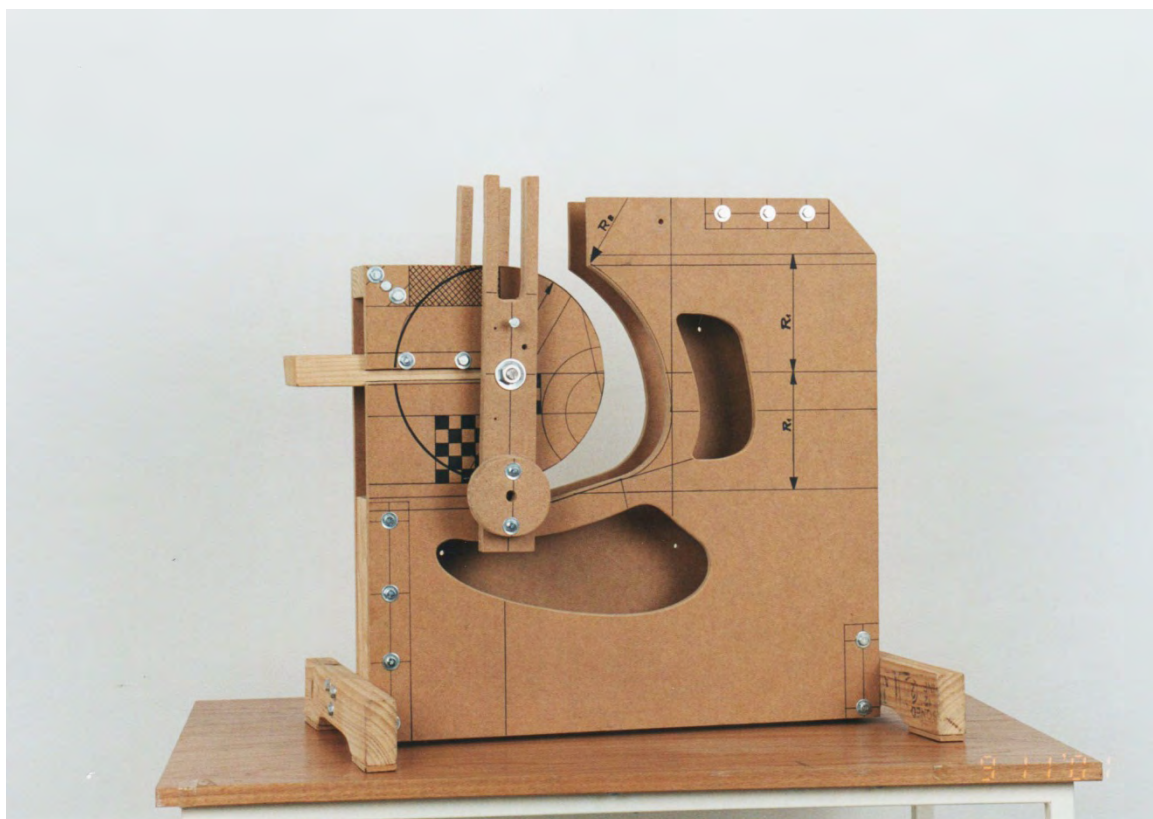
Always The Case of Give and Take!!” Although the page is covered by words, which look fine at a glance, but on close examination there is no coherent message/conclusion. Choices between derailment and poverty of content are subjective to a large extent – another reader may call this incoherence. The current author is calling this poverty of content – an example of the patients later work will be presented under incoherence.



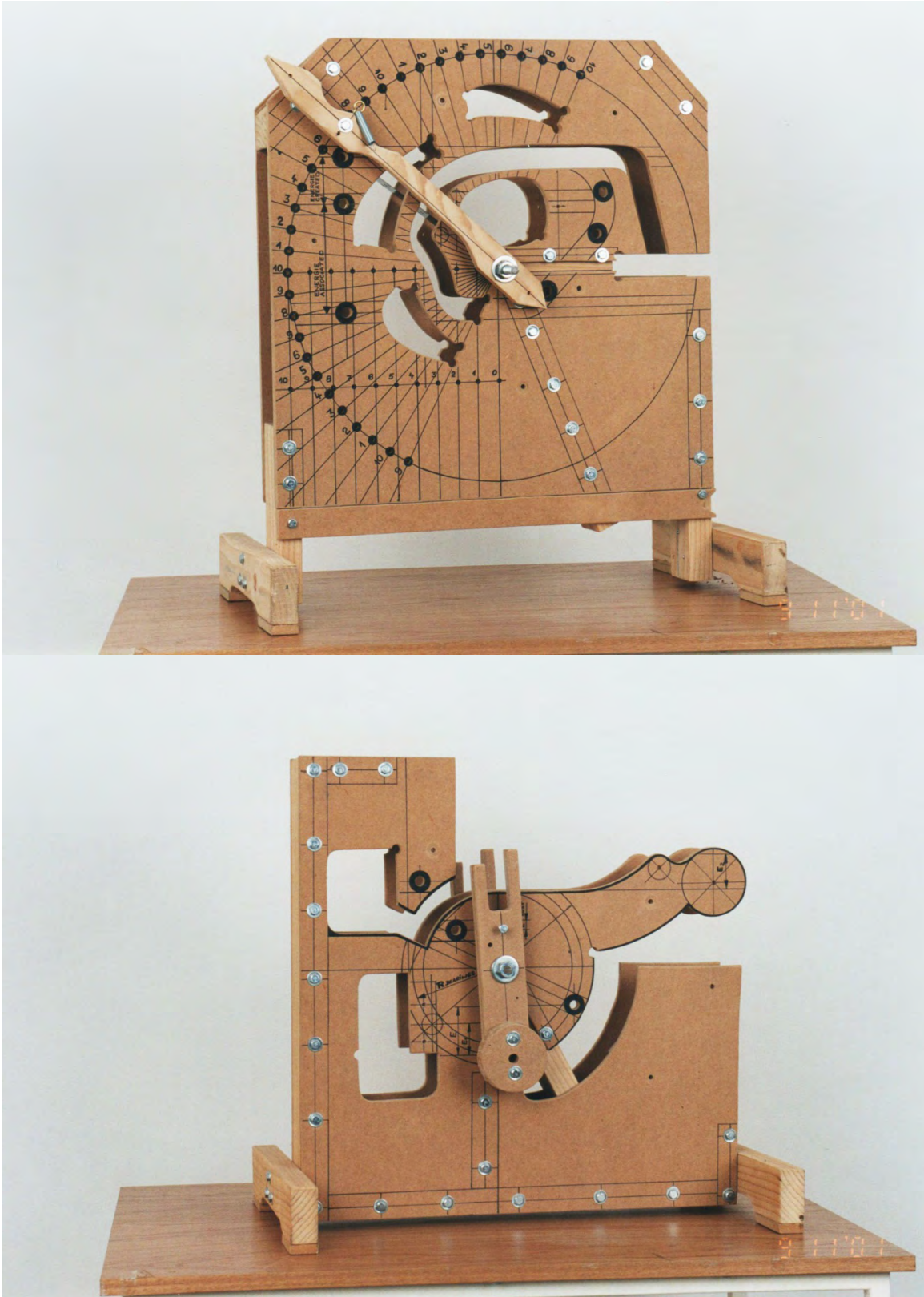
Figure 35. This drawing was made by a young man with schizophrenia. He left it in a psychiatric ward and was not seen again (40 years). When asked what he had drawn, he answered, “An Abstract Living View”. He could not give a clear statement about the title, or the drawing. The components appear to include a vine with leaves and fine roots. The circle in the middle is likely a seed and a tuber or bean shoot extends downwards. To the left of the vine is the head of the dragon from the movie, “Neverending Story”. The style is delicate, the roots, leaves and dragon’s head are delicately detailed. This could perhaps pass as abstract art, but because the drawer designated a difficult to understand title, and could not give any explanation, it is presented here as a possible example of poverty of content of thought. He applied himself for long enough to attend to fine detail, and the current

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author prefers poverty of content over planned abstract art and “incoherence”.



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Figures 36-38 . These are three of a dozen “machines” made by a middle-aged man with schizophrenia. The drafting and workman ship were

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excellent – circles were perfectly concentric, Bolt holes matched up exactly, and nuts were brought to the appropriate degree of tightness. The wood was clean and smoothed.

But none of the machines were finished or functioning. When asked what the machines were for, he could not give a clear explanation, and the purpose of each machine appeared to change over time. The patient claimed these were “time machines” and “perpetual motion machines”. Certain dimensions had to do with racial characteristics and when certain levers were moved, certain moral and scientific principles were/would be demonstrated.

The current author suggests this work indicates poverty of content – There is high quality workmanship, each machine took weeks to construct, and they were designed to perform particular tasks. Against this, they could perhaps be considered the product of incoherent thought, as precise principles and functions could not be explained.

Incoherence

Incoherent thought is incomprehensible due to extreme loss of logical connections, distortion of grammar and idiosyncratic use of words. (Figures 39 & 40.)

An example from Andreasen (1979).

Clinician: “What do you think about current political issues like the energy crisis?”

Patient: “They’re destroying too many cattle and oil just to make soap. If we need soap when you can jump into a pool of water, and then when you go to buy your gasoline, my folks always thought they should get pop, but the best thing to get is motor oil, and money”.

The current author speculates that the mechanism underpinning derailment, when present to a greater degree results in poverty of content, and when present in an extreme degree results in incoherence. This may be incorrect, of course, and different mechanism may be involved.

The term ‘word salad’ has been used to describe this phenomenon. Although some authors (Kaplan and Saddock, 1991) give separate definitions, the current author recommends using only one term: incoherence.

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Incoherence due to psychiatric disorders is not uncommon. It is evidence of severe disorder and is found in schizophrenia and mania.

Incoherence can sound like dysphasia and neurological investigation is mandatory in the event of sudden onset. Intoxication with a wide range of stimulants and other agents needs to be excluded.

When twenty Jacks were actually
 sixteen jacks four colours of each
 this went into percentages of
 provided for peoples being a forgotten
 four percent then the calculations
 to be observed were only up to
 0-2-4-6-8-10-12-14-16-18-20
 20 being 11 sizes of a weekly wage
 faeries representations - sizes up to 50
 Dae reckon

Figure 39. This was written by a middle-aged woman with schizophrenia who drifts around the country finding herself in one psychiatric ward after another. She appears to start writing about the game which was called "Knuckle bones" similar to the American game of Jacks. In "Knuckle bones" the "bones" are made from plastic, in bright colors. She then goes off into numbers and mentions Faeries. She ends with "Dae reckon". At times she spoke with an American accent and purposefully wrote "Dae" for 'They'. It is impossible to grasp her meaning.

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MEDICAL RESEARCH.
EXAMINATION OF HEAD.
 (1) PROFESSIONAL (2) NON-PROFESSIONAL.
 EFFECT OF POLISHING OF SHOES OVER
 THE TIME BETWEEN THIS POLISH AND THE
 NEXT POLISH.
 UNCONSCIOUS OBSERVATIONS AND AFFECT
 UPON HEAD OVER THE LIFE SPAN OF
 A HUMAN BEING. - SERVICE BOOTS AND
 CIVILIAN SHOES.
 A BIOLOGY STUDY OF GARDENING
 AND FARMING FRATERNITIES - EFFECT OF
 PROCESS OF BUILDING UP SOIL AND
 HUMUS IN THE SOIL - VARIOUS TYPES OF
 SOIL. - SEA AND GEOLOGY STUDIES.
 THE PROCESS OF DRY-FIREWOOD UPON
 HEAD (CUTTING.) AND A RELATIONSHIP

Figure 40. This was the first page of a number of books written by the same man who wrote Figure 34. Here he starts with a heading about "Medical Research, Examination of the Head", but his opening lines are about the "Effect of polishing of shoes over the time between this polish and the next polish". He returns to "Affect upon the head" but then goes on to "Service boots and civilian shoes". In the opinion of the current author (but others may disagree) there has been deterioration, and this is presented as an example of incoherence.

Poverty of thought (speech)

Speech is decreased in amount. There is little if any spontaneous output.

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Answers may be delayed and often monosyllabic or brief and unelaborated. Some questions may be left unanswered altogether. The interviewer will have to keep prompting and asking for elaboration to get much information.

Clinician: “Do you have children?” If the answer is in the affirmative, the healthy individual usually responds immediately, stating the affirmative case and usually giving the number and sex, often the ages and sometimes even the names, of the children.

Patient: The patient may not make any response when the question is first asked. The interviewer may ask the question a second time and after a long pause the patient may answer, “...Yes...”, often without any supplementary details. Even the word ‘yes’ may be mumbled or otherwise unclear.

Poverty of thought is common in chronic schizophrenia, where it is often accompanied by other ‘negative’ symptoms. Here it appears to be due to abnormality in mesocortical projections and prefrontal cortical cellular architecture. Depression may also present with poverty of thought, but less commonly. A core feature of depression may be slowness in the production of thoughts (psychomotor retardation), and speech may cease altogether (depressive stupor).

Two main organic conditions need exclusion hypothyroidism and dementia/ frontal lobe damage. Slowness of mentation (and other physiological processes) is well established in hypothyroidism; in dementia/ frontal lobe damage there may be lack of conversation due to apathy.

Neologism

Neologisms receive attention in textbooks, but they might not exist. In 40 years of clinical work, the current author has, at most, seen two. They are unlikely to be important.

The definition of neologisms is unclear. Rifkin (1991) states they are

- new words are invented by the speaker
- words are distorted
- standard words are used in an idiosyncratic manner.

Andreasen (1979) reserved the term neologism for those items, the

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derivation of which cannot be understood, e.g., ‘a tavro’ and ‘replaper’. She suggested a separate category of ‘word approximations’ for new words developed by the conventional rules of word formation, e.g., ‘handshoes’ (gloves).

At this time, in clinical practice there is no clear benefit from distinguishing between new words, word approximations and word distortions (research may change this position), and it is recommended that they be grouped together as forms of neologism.

A remarkable feature is that the patient seems unaware that neologisms lack meaning to the listener. When the examiner stops the conversation and asks what a particular neologism means, the patient usually still shows no surprise, but depending on the degree of thought disorder, may answer as if defining a standard word.

In the clinical experience the current author a woman with probable schizophrenia persisted in mispronouncing the city, Melbourne. She said (phonetically) “Melvern”. She could say the word correctly, she acknowledged that she pronounced it differently to others, but she could not give a reason for so doing. The other apparent case is illustrated in Figure 41.

Neologisms are very rare, but may occur in schizophrenia or mania. in a very small percentage of those people suffering schizophrenia or mania. In the case of a patient with frequent neologisms, dysphasias would need to be excluded.

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Dear Dr. X ,
 I worked out
 with my automatic supersonic
 mind that I have been
 suffering from Torpor cancer.
 It is a form of leukemia
 in pregnant? women.

Figure 41. This letter was written by a woman with chronic schizophrenia. She sent hand written copies (exactly the same words) to a large number of the doctors (including junior/trainees) who had cared for her in the past. Interestingly she referred to her “automatic supersonic mind”, which might suggest mood elevation, but grandiose delusions also occur in schizophrenia (such people don’t make a fuss about their gifts, but quietly savor them). The apparent neologism is “Torpor” cancer, which she states is a form of leukemia. She was examined and found not to have leukemia, and to be well past child bearing age.

Blocking (thought block)

Though blocking is described as an interruption in the train of speech/thought before the thought is completed. Patients stop speaking, then after a period of seconds to minutes, indicate that they are unable to remember what they had intended to say. To make a diagnosis the patient must volunteer or confirm on questioning that they have lost their train of thought.

It is rare, and over-diagnosed. Cessation of speaking or failure to answer may suggest, but do not prove thought blocking. Care must also be taken not to claim this symptom when the patient is simply distracted by delusions or hallucinations.

Blocking may give rise to the delusion that thoughts have been withdrawn from the head (thought withdrawal).

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True thought blocking must be distinguished from the benign form that occurs in normal individuals. In this form the symptom arises as an isolated event, more often when we are tired or distracted by other thoughts. It is seen in schizophrenia. In mania there may be loss of a train of thought, but the patient does not appear concerned that the topic has been lost—rather, they pass on to the topic which distracted their thinking.

Echolalia

Echolalia is the pathological repeating of the words or phrases of another Person.

It is rare in psychiatric disorders, but may occur in schizophrenia and mania (more frequently in severe cases). Echolalia occurs in organic conditions, particularly in dementia complicated by dysphasia and in some individuals with mental retardation.

Perseveration

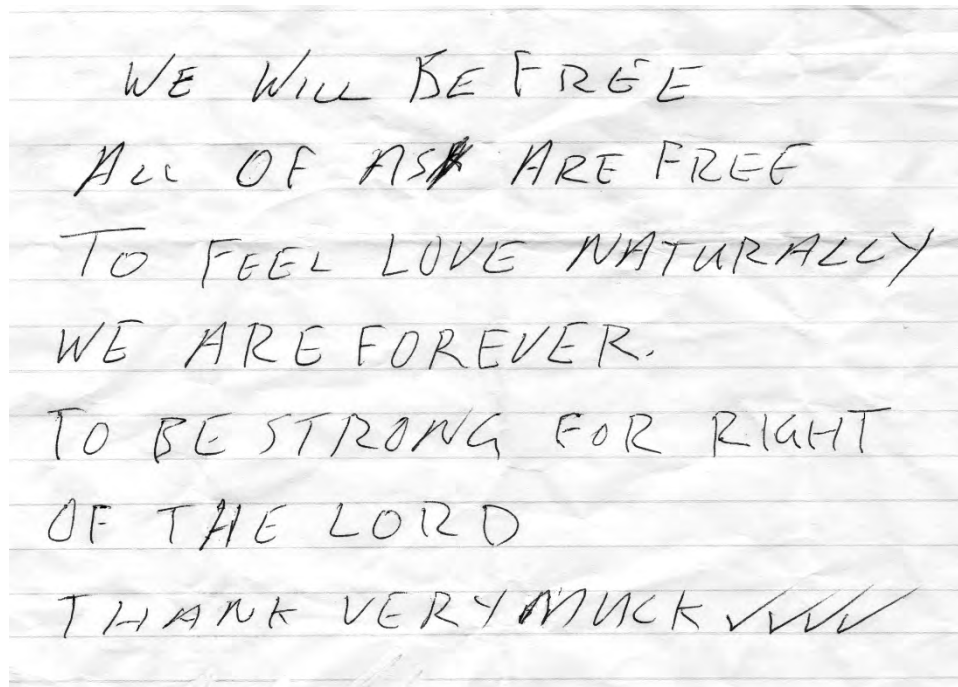
Perseveration is the repetitive expression of a particular word, phrase or concept during the course of speech.

Repetition of a concept is common in psychiatric practice, people persecutory delusions talk frequently about their concern, people with anxiety talk frequently about their fears, and people with major depressive disorder will frequently talk about their problems, but this is not usually termed perseveration.

The example of perseveration given by both Andreasen (1979) and Rifkin (1991) is of a man who said, 'I think I'll put on my hat, my hat, my hat, my hat.' This form of perseveration is rare in psychiatric disorder.

Figure 42 is an example of the repetition of a phrase, while Figure 43 is presented as the perseveration of a concept.

Perseveration is found in schizophrenia, but is rarely of major diagnostic significance. It occurs in organic conditions and such conditions must be excluded.



WE WILL BE FREE
ALL OF AS~~A~~ ARE FREE
TO FEEL LOVE NATURALLY
WE ARE FOREVER.
TO BE STRONG FOR RIGHT
OF THE LORD
THANK VERY MUCH ✓✓✓

Figure 42. This note was written by a young man suffering schizophrenia, who in conversation perseverated the phrase, "Thank you very much". Here he had written a vague, but encouraging message, and somewhat inappropriately, ended it with "Thank you much" (it is reasonable to suppose the omission of "very" was unintentional). Each time he read his message, he gave the "Thank you much" line a tick – which is assumed to be an unusual form of phrase perseveration.

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black onto

SCHIZOPHRENIA : occasional epilepsy, liar, gossipers, tale teller, bragger, boaster, thief, hoarder, murderer, suicidal, Prime Minister, President, King or Queen, politician, magistrate, lawyer, juror, school teacher, religious, non-believer, Christianity, ~~and~~ drug abusers, smoker, tradesman, worker ~~and~~ alcoholic, dreamer, wealthy and poor man, busy body, nosey poke, traitor, deceiver, actor, doctors, nurses, fools, artists, planner, architect, poet, minister, Pope, school teacher, musicians, explorer, motorist, black-mailer, selfishness.

Figure 43. This note was written by a twenty-two-year old university student who had been diagnosed as suffering from schizophrenia. He rejected the suggestion that he was mentally ill. To prove he did not have schizophrenia he went to a standard English dictionary, found the word schizophrenia and compiled the above list, which he presented to the current author at our next meeting. Poignantly, his list substantiated rather than disproved the diagnosis. It is replete with derailment and perseveration. It is not clear why the derailment occurred from 'SCHIZOPHRENIA' onto the topic of epilepsy. Next came the word 'liar', which could have referred to the current author, but then he perseverated on people who are careless with the truth, "gossiper, tale teller, bragger, boaster". At another point he lists heads of state and government positions "Prime minister, President, King or Queen, politician", before derailing through a number of steps to the word 'Christianity'.

Alarmingly, a number of nefarious activities, "busy body, nosey poke, traitor, deceiver, actor" leads directly to "doctors, nurses, fools". There is a large amount of psychopathology in this document. It illustrates derailment, poverty of content and lack of insight, but is presented here because, in spite of the marked derailment, there is a strong sense of perseveration. There is perseveration of the intention to disprove the diagnosis of schizophrenia and his perseveration of the use of his chosen method, listing words from the dictionary.

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Illogicality

Illogicality is a difficult, possibly unnecessary concept, and is included for the sake of completeness. (Figures 44 & 45.)

Illogicality is defined as the presence of erroneous conclusions or internal contradictions in thinking.

The vast majority of delusions can be disproved by evidence, yet when faced with convincing evidence, the patient continues to believe the delusion. Thus, it can be said that all delusions depend on illogicality.

However, in the current context, there needs to be an internal contradiction in the thinking. Such as when the patient reports that he has just been looked at by a man, and when this man looks at people they immediately burst into flame. If the patient is not on fire, there is internal illogicality in his/her statement. However, in clinical experience, when this point is communicated to the patient, there will be a further delusional explanation. If he/she advises that he/she is God and cannot be damaged, the illogicality is defunct.

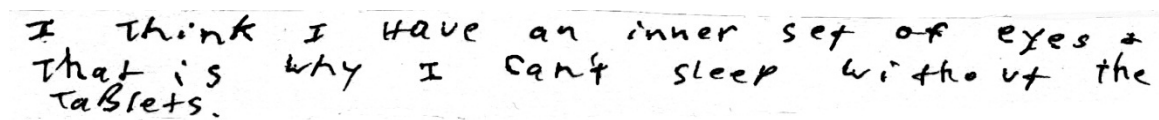
Illogicality, then, is a difficult category, which survives in disputed territory between disorders of thought form and content. The term is rarely helpful in clinical practice (and often only confuses).

The thoughts of normal people reveal a good deal of illogicality, when closely scrutinized. Nevertheless, when clear examples of illogicality occur they suggest delusional disorder and schizophrenia. Intoxication may need to be excluded.

IN THE BEGINNING THERE WAS NOTHING
NOTHING IS SOMETHING!
THEREFORE: IN THE BEGINNING THERE WAS
SOMETHING.
THEREFORE: THERE IS NO BEGINNING.

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Figure 44. This passage was written by a young man during an acute episode of schizoaffective disorder. He carried a writing pad and made notes throughout the day, apparently to him control disorganized thinking. The passage is an example of illogicality of thought. This is an example of the apparently clever word play of some young people with schizophrenia and mania.



I think I have an inner set of eyes & that is why I can't sleep without the tablets.

Figure 45. This was written by a young man who suffered schizophrenia. Here he states that he needs tablets to sleep because he has 'an inner set of eyes'. This may be interpreted as the statement of a delusion. An alternative, speculative explanation for this statement involves formal thought disorder—the patient found that he could not sleep without medication—he knows that one's eyes close when one sleeps – but, when he closes his eyes cannot sleep. He makes the illogical conclusion that he has a second pair of eyes which do not close. This example may not satisfy the definition of internal inconsistency, but it seems logical to the current author.

Content

Disorders of content of thought have a profound effect on the mental life of the individual, influencing subsequent thinking, feeling and behavior. They are often immediately apparent at interview, and often constitute the presenting complaint.

When a patient presents with a complaint which is secondary to a disorder of content of thought, such as insomnia secondary to the belief that attack by an enemy is imminent, both the primary and the secondary problems may be listed under the heading of presenting complaint. Alternatively, the secondary problem may be listed as the presenting complaint while the primary problem is listed in the history of the presenting complaint.

Disorders of content of thought are usually mentioned under the heading of presenting complaint (or history thereof), but as there is also provision

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for mention of content of thought under the heading of mental state, interviewers are sometimes uncertain about emphasis and repetition. The following is an acceptable arrangement. Complete details are given under the heading of presenting complaint (or history thereof). These are followed by the rest of the history. In the mental state, under the heading of content of thought, some brief reminding details are offered and the reader or listener is referred back to the presenting complaint for the complete account.

Individuals with disorders of the content of thought believe things that the interviewer does not believe (i.e., the patient is being watched by people from another country, political system or planet). The interviewer, may be concerned about what to answer if asked the “Do you believe me?”. In clinical experience, this question arises relatively infrequently. This may be because the patient is occupied with the thoughts, and is less interested in the interviewer’s thoughts, and usually patient has argued the issue with numerous people before coming to the diagnostic interview and no longer expects others to share his/her beliefs. However, when the question does arise, it is appropriate to indicate that the interviewer believes the patient, but not the belief, for example, ‘I believe you believe what you are saying’. Once asked this question, the interviewer has the opportunity to strengthen the relationship, with, for example, ‘I know you’re telling me the truth as you see it, but I’m not sure I can agree, because...’. [The advantages of this response are: the statement by the interviewer that the patient is telling the truth, which is polite and positive; it gets away from the complicated issue of ‘belief’; and it respectfully invites the patient to explore other explanations. The point of this invitation is not so much a therapeutic endeavor (it is unlikely that, in the early stages at least, a patient will be persuaded away from a delusional conviction), but a means of assessing the extent of the delusional system and the strength of the conviction.]

Delusion

Delusions are false beliefs that are sustained despite evidence to the contrary, and are out of keeping with the patient’s social, cultural and educational background.

The following are useful terms. Some apply to the subject matter of the delusion, such as parts of the patient’s body (somatic), harassment

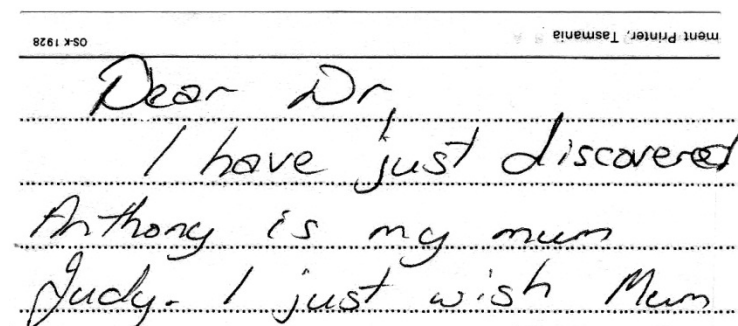
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(persecutory) or self-accusation (guilt). Others refer to other aspects of the mental state (mood-congruent and mood-incongruent) and yet others refer to the degree of organization within the delusion (systematized). Except for mood-congruent and mood-incongruent, these are not mutually exclusive terms.

No delusion is pathognomonic of any mental disorder - any can occur in any psychotic disorder - but some are more suggestive of certain disorders than others. No ranking in importance is possible or intended.

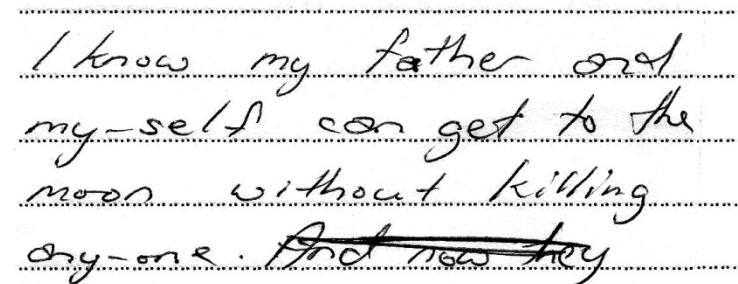
Bizarre delusions

These delusions are absurd, implausible and factually not possible. (Figures 46-48) The subject matter often includes the supernatural or space creatures. Bizarre delusions are found in schizophrenia, mood disorder and organic states.



Dear Dr,
I have just discovered
Anthony is my mum
Judy. I just wish Mum

Name of patient
and some relatives
withheld.



I know my father and
my-self can get to the
moon without killing
any-one. And now too

Figure 46. This note was written by a young psychotic man and given to the current author. In the first three lines, states the belief that a male nurse is actually his mother (Judy). This is a delusional misidentification syndrome.

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In the last three lines the patient makes the bizarre delusion that he and his father can get to the moon.

I'm convinced that krypton exists
and superman & wonder woman (etc) exist -
& some of the people can joint from
one place to another & that they can
get anything they want through their
Blood.

Figure 47. This was written by a young man who suffered schizophrenia. He had the bizarre belief that Superman and Wonder Woman were actual beings. He has written that they could "Joint" from place to place – he probably meant 'jump', however, there is a possibility that "Joint" is a neologism.



Figure 48. This "Cursing jar" was so labeled an operated by a young man with schizophrenia. He was socially isolative and secretive and brought to

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hospital by his parents. His parents told that he had written "Cursing Jar For Good" on the lid of a mustard jar. He wrote curses on strips of paper against his enemies which he kept in the jar. These curses all began "I cast that...". His parents told that he behaved as if the curses were a serious matter, and they expected his curses to be effective.

The idea of a "Cursing jar" seemed to have come from a fashion some decades of having a "Cussing jar" in offices and other places of work into which employees put money if they used bad language (cussed/swore) the contents being episodically donated to charity.

Grandiose delusions

These are delusions of ability, beauty, influence or importance - they are beliefs that are inconsistent with the patient's assets. (Figures 49-51.) They are frequently present in mood elevation, as occurs in mania, and intoxication with stimulants and euphorants. They are also a feature of paranoid conditions.

(TOO SCARED BY THE TRUTH TO KILL). I HAD TO GO WORLD WIDE
 (THEY WOULDN'T EVEN SAY HAPPY CHRISTMAS). I KNEW THEY
 WOULDN'T KILL ME, THE WHOLE WORLD KNOWS I'M
 INNOCENT, THE WHOLE WORLD KNOWS I'M SPECIAL.
 UNFORTUNATELY SO MANY ARE GOING TO HELL. THERE ONLY
 HOPE WAS THAT I WOULD GO MENTAL UNDER ALL OF THE
 PRESSURE AND THEN THE PUBLIC WOULDN'T BELIEVE THE
 MESSAGE. THEY COULD SEE PEOPLE CLOSE TO ME DIDN'T BELIEVE.
 THEY KNOW THAT NOBODY HAS TOLD ME YET THAT
 THEY BELIEVE. I KNOW THAT I'M FAMOUS. THEY JUST
 WANT TO GO TO HELL IN PEACE. NO SUCH LUCK.
JANUARY: BEEN SPIED ON BY THE WHOLE WORLD
 WHILE LIVING IN A HOVEL EATING TEA AND BREAD AFTER
 TRYING SO HARD TO GIVE THE MESSAGE IN PEACE.

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Figure 49. This is part of a many page document written by a young man with chronic schizophrenia. There is much psychopathology, from FTD to the experience of being spied upon, bugged, and persecuted. It is presented here to demonstrate grandiose delusions. Four lines from the top he underlines, “The whole world knows I’m special”, five lines from the bottom he states, “I know that I’m famous”.



Figure 50. This plastic bag containing faeces was found in the luggage of a young psychotic man who was visiting from another part of the state. He was well dressed and came from a prominent family. He explained that he believed his faeces contained gold dust, which he did not want to waste by placing in a toilet. He made a good recovery and was later embarrassed by his grandiose delusion.

MY ① CONFESION

8.6.2008

FATHER
Name

Secure Treatment Facility

I HAVE TO CONFESS, THAT
I THINK THAT I AM THE
ATOM AGE PROPHET
ELIJAH SORT OF JOHN
THE BAPTIST, WHO WAS
THE FORERUNNER OF JESUS
CHRIST. FATHER I AM

Figure 51. This “Confession” (first paragraph of 8 pages) was written to a Priest by a man being held indefinitely in a secure facility, as representing a danger to the public. He copied this document multiple times and sent copies to the judiciary, and a host of lawyers and doctors of the city in which he lived. He confesses that he thinks he is “The Atom Age Prophet Elijah sort of John the Baptist” etc.

Persecutory delusions

These are delusions of being harassed, persecuted, cheated, threatened, watched or bugged. (Figures 52 & 53) These delusions may involve God and/or the devil, space creatures, spies, communists, religious groups to which the patient does not belong, homosexuals or neighbors. They are found in all forms of psychosis.

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Dr. Pittmore

The Hobart Police Station
 has a surveillance room of hell and that's
 exactly what they have be doing.
 They have powerful x-ray machines that can see
 through your homes all buildings your cars buses
 etc boats planes as they can see you clearly in
 the streets, they don't need any cameras
 a bad lot took the room over they gathered
 themselves together, they were put behind the
 screens to police. They surveillance the city harbour
 the land and of course your homes as well as

Figure 52. This is the first paragraph of a nine page letter written to the current author by an elderly woman who lived on the streets most of the time because she was too afraid to sleep in any accommodation. She was insightful and refused all treatment. Here she says that the Hobart Police Station has a very powerful X-Ray machine by which they can see into our homes. She suffers a severe delusional disorder.

Battery operated people with big Zips
 up their backs if I got a big magnet
 you'd all stick to it
 I'm the only one here who's not
 like that and I don't know who
 I can trust cos there only robotick
 people. Sometimes they get stuck
 and go up and down in the same
 place. My life is threatened
 They have little antennas and communicate
 with each other
 It's a very scary thing to know that
 the whole world is like that
 I have to get out of here.
 Why won't they leave me alone
 what have I done that is so terrible

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Figure 53. This note was handed to the nursing staff of a Psychiatric Intensive Care Unit by a young psychotic person. She states that the staff are all robots with zips up the back and antennas. She states that sometimes they go up and down in the same place. This description is reminiscent of some fury toys which have batteries inserted from behind. This delusion is of a misidentification type and could have been placed under other headings. It is placed here because of the persecutory nature, “My life is threatened”, and “It’s a very scary think to know that the whole world is like that – I have to get out of here”.

Delusions of reference

Things that other people do or have done are believed to refer to the patient. Items in print, the things said on radio or television or actions of people in the street (such as coughing, covering the mouth or crossing the road) are believed to have special meaning - usually telling the patient or other people of the patient’s past or present deeds. (Figures 54 & 55.) The patient is frequently ‘innocent’ of these deeds or attributes. For example, the coughing of a stranger in a shop may be taken as a communication to others in the shop that the patient is a child molester or homosexual when neither is the case.

Delusions of reference are found in all forms of psychosis. In mania, they usually refer to the patient’s superior qualities, and in schizophrenia they are often threatening.

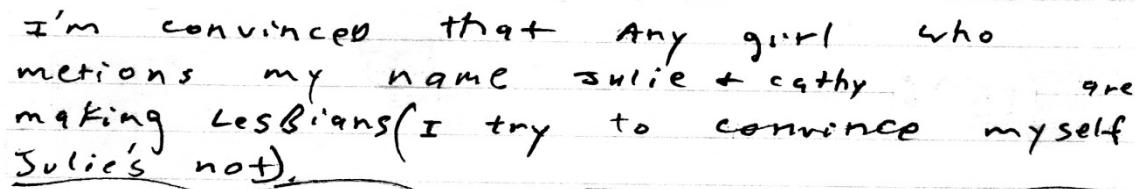
‘Ideas of reference’ may occur in psychotic and non-psychotic disorders. They lack delusional strength. Patients can be convinced that although ‘it seems like it’, the actions of others do not, in fact, refer to them.

Ideas of reference may occur in social phobia, where the patient has the experience that others seem to be aware of his or her discomfort. However, the term is rarely used in non-psychotic conditions because of a strong association with psychotic conditions.

“...of the Sydney Edition. There is even a horse running around now called West Ryde King. Don’t patronize me fellas. These murders are still...”

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Figure 54. These two lines are taken from a long document which was circulated around Australia, to the Judiciary, Police and Mental Health Services. The full document is presented under Systematized Delusions. This man's delusions focus on the West Ryde golf Links. The name of the race horse 'West Ryde King' he took as a reference to himself, hence, "Don't patronize me fellas".



I'm convinced that any girl who mentions my name Julie + Cathy are making Lesbians (I try to convince myself Julie's not).

Figure 55. This was written by a young man with schizophrenia. It contains much FTD and it is therefore unwise to comment with certainty. 'Julie' and 'Cathy' were characters in a long running TV soap opera. The patient was infatuated with both, particularly 'Julie'. The presented piece can be read as meaning that when the patient heard a female mention his name, he took this to indicate that 'Cathy' and 'Julie' (the objects of his desire and regard) were lesbians.

Delusions of control

Patients believe some external force is controlling their thoughts, feelings or movements, and they may complain of loss of autonomy or feeling like a robot. (Figures 56 & 57.)

They may state that they do not 'will' certain of their thoughts or actions, it is as if these are 'willed' by an external force. This does not include being influenced by a person, idea or God, unless there is loss of control to this external force.

4

enclosed space. They are trying
to control me so I'm not
able to have freedom. I'm not
sure what's the race of these
people - it's a very ~~unhappy~~ way
for me. I can't tolerate them
much longer. What I do is
monitored - all this coming
from a machine! I can't use
1999
seethes - back of this head feels
controlled by something else or ~~some one~~
else. Pain from that area makes me

Figures 56 & 57. This is the fourth page and a small piece of the sixth of a seven page letter which was sent anonymously to a general hospital. The author was never identified and may have been a person passing through the state. She suffered severe auditory hallucinations and other psychopathology. This piece is included here because she writes "They are trying to control me..." At the bottom of the page she writes, "...all this coming from a machine".

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On page six she has written “back of this head feels controlled by something else or someone else”.

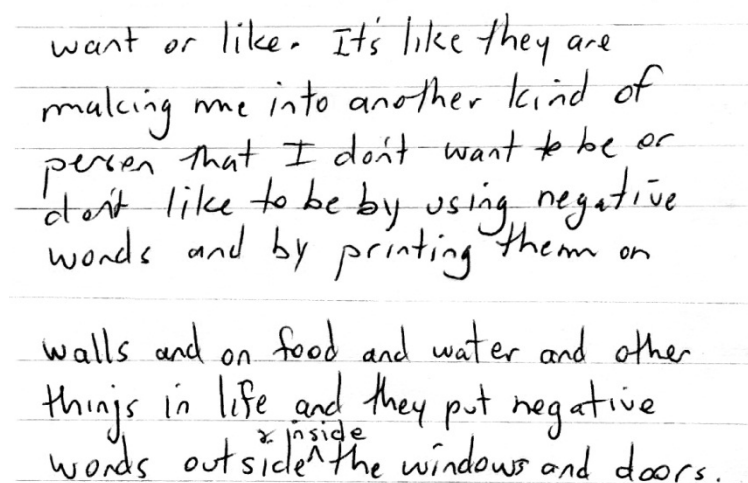
Thought withdrawal

The delusion that thoughts are being removed from the head. This is usually secondary (an explanation) to thought blocking (see above).

Thought insertion

The delusion that thoughts are being inserted into the mind by external forces.

This is a relatively uncommon phenomenon. Figure 58 illustrates a possible example.



want or like. It's like they are
making me into another kind of
person that I don't want to be or
don't like to be by using negative
words and by printing them on
walls and on food and water and other
things in life and they put negative
words outside^{& inside} the windows and doors.

Figure 58. This abstract comes from the letter mentioned in Figures 56 & 57. The patient reports that others are “using negative words”, stating that they these negative words are being printed “on food and water” and being placed “outside and inside the windows and doors”. This is a psychotic experience, and such experiences sometimes defy description. While this description may refer to visual hallucinations, the patient is states that “they” are trying to make her into “another kind of person”, thus, there is a reasonable possibility she is describing thought insertion.

Thought broadcasting

The delusion that the patient's thoughts can be heard by other people. A cautionary note - the belief is that the thoughts are actually heard by others - it is not simply that others know what the patient is thinking.

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Nihilistic delusion

The delusion that part of the self, the entire self, others or parts of the world do not exist or are in the process of ending. (Figure 59.)

Nihilistic delusions are not common. It is possible that patients will believe they are dead. When it is demonstrated to the patient that they are still alive, he/she is unable to mount a counter argument. He/she may look a little embarrassed but they are not convinced by contrary evidence, and continue to worry. Another manifestation is the delusion of poverty – even though family reassure them. In response to evidence that they have money and investments, affected people may argue that these resources are insignificant and inadequate given the rate of inflation and potential debts.

Characteristically, nihilistic delusions occur where there is depression of mood, such as in major depressive episode or in the depressed phase of schizoaffective disorder.

The voices have convinced me there is
part of my Brain or Body is
missing

Figure 59. In this example, a young man with schizophrenia is convinced that part of his brain or body is missing. It is not clear what he means by “the voices have convinced me” but, such a delusion can arise quite independently of hallucinations.

Somatic delusion

A delusion about a part of the patient’s body, which may be bizarre, such as ‘My brain has been replaced with a cat’s liver’, or non-bizarre such as the delusion that the patient has cancer of the rectum in spite of total absence of evidence. (Figure 60.)

Some patients with somatic delusions are concerned that they emit a foul smell from their skin or orifices. Others believe their bodies (particularly their faces) are misshapen or ugly, despite evidence to the contrary.

The belief of the person with anorexia nervosa that they are

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overweight may be held with delusional intensity, but this is accepted as an integral part of that condition and the term somatic delusion is not usually applied.

Hypochondriasis, according to current descriptions, is an overvalued belief that one is suffering a disease, but this belief is not held with delusional intensity. Somatic delusions are most usually encountered in schizophrenia, depression and delusional disorder.

‘Body dysmorphic disorder’ is preoccupation with an imagined defect in appearance. This may lead to impairment of social functioning and the pursuit of cosmetic surgery. If the thought is held with delusional intensity the condition is classified as delusional disorder, somatic type.

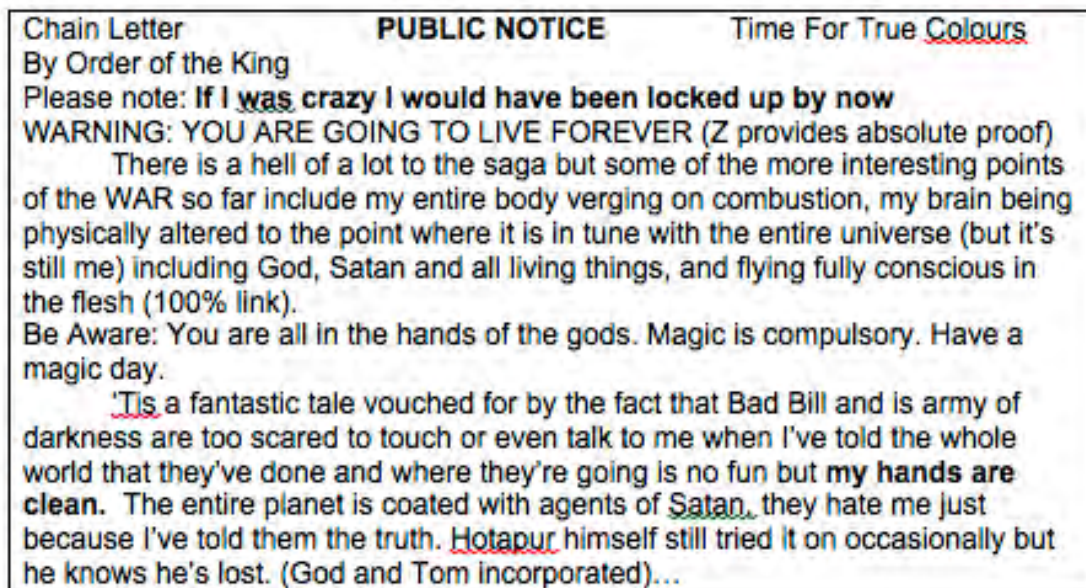


Figure 60. The above “public notice” was part of a one page document widely distributed, throughout a city, by its writer. The full document is not presented because the second half made accusations against named people. The writer believed the owners of a coffee lounge were persecuting him. One night he burned the business down. He was jailed and died by suicide in prison.

The document contains a large amount of psychopathology including paranoid and grandiose material. However, the document is presented here because of the line “my entire body is verging on combustion, my brain being physically altered to the point where it is in tune with the entire universe”, which suggests somatic delusion.

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Delusions of guilt

This term is applied when patients incorrectly believe they are guilty of, or responsible for, a certain act or set of actions which had a detrimental effect on others. (figure 61.)

Many patients believe they have let their family or work mates down by being sick and unable to fulfill their role. This usually does not constitute a delusion of guilt. It is usually not held with delusional intensity—the patient will usually agree they are not responsible for their episodes of illness. Further, it is a fact that family and work mates will be inconvenienced by the patient's absence, thus there is usually no break with reality.

True delusions of guilt are not difficult to identify. One example is of a man who was severely depressed and suffering, who attributed his current state to the fact that he had stolen some stamps for his stamp collection as a boy. He had psychomotor retardation and could not give a lucid account - it was not clear whether he believed that the stealing of the stamps set in train events which resulted in his present situation, or whether this was his punishment, handed down by some moral authority. He was suffering a delusion of guilt whatever his explanation and irrespective of whether he could give one.

Another example is a woman who believed she was responsible for a food crisis in Africa because she had been eating at expensive restaurants. She described a cascade of events beginning with her wastefulness, involving a downturn in the Australian economy, and ending in a reduction in Australian financial support for developing economies.

Delusions of guilt occur most frequently in depressive disorder.

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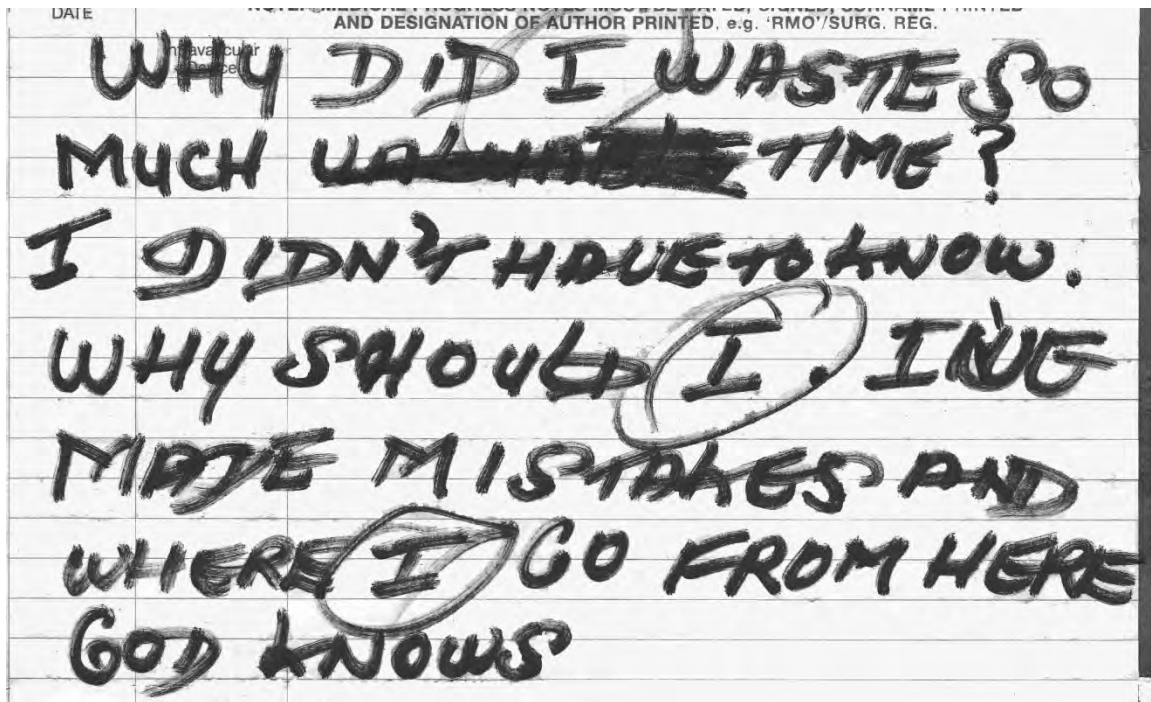


Figure 61. Written statements relating to guilt are rare, probably because most are found in psychotic depression, and this level of depression is associated with psychomotor retardation or agitation, and the patient is in no condition to be writing. This example is at the lower end of severity, there is not the belief that others have suffered as a result of the patient's actions, but that the patient had wasted his/her time. However, the making of mistakes is mentioned.

Delusional jealousy

Delusion that one's spouse or lover is unfaithful. This delusion often results in checking the partner's clothing for stains and pubic hair, and may result in the patient assaulting the partner.

Delusions of jealousy may be a feature of any psychosis. As the primary feature of what was called morbid or pathological jealousy (DSM-IV terminology is delusional disorder, jealous type) it is most often found in chronic alcohol use.

Erotomantic delusions

Delusion that another person (usually a high-status person) is in love with the patient. This usually results in efforts to contact that person, telephone calls, letters, gifts and personal appearance. It may result in stalking and other forms of harassment. The advances are eventually rejected

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and legal consequences such as restraining orders and charges of assault may result.

Knowing this condition exists, one sometimes notes accounts in the press, which appear to have gone undiagnosed. This condition is most frequently a feature of delusional disorder, erotomanic type.

Mood congruent delusion

The term is only applied in mood disorder, where the delusion has mood appropriate content. For example, a depressed person believes his family has been murdered, and cannot be reassured, even when they visit.

Mood incongruent delusion

Again the term is only applied in mood disorder, and in this case, where the content of the delusion has no association with mood. For example, a depressed person had a non-threatening delusion that his car had been used in the making of a film, although the film was made in USA, using American cars and the patient's car was of a type exclusively manufactured and sold in Australia.

Systematized delusions

Delusions united by a single theme (also referred to as a delusional system). Systematized delusions may be a feature of any psychosis, but are most commonly found in delusional disorder and schizophrenia. (Figure 62.)

THE CASE FOR MARTIN BRYANT

16 October 1996

The reason Martin Bryant did what he did was because of an electronic mind control center located under the 10th fairway at West Ryde Golf Links and I will proceed to prove it.

In 1985 when I was living in Queensland I started, all of a sudden, getting strange dreams of other people's experiences, usually sex, sometimes even before I was asleep. In one of these experiences I noticed lines through the image, like looking close to a television set, and being experienced in electronics, I realized it was being done electronically. This scared me so much that I left Queensland and went back to my parents place at xxxx Avenue, xxxxx. At that time I thought I was chosen because I used to hang around the stables at the Queensland Racecourses.

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It took some eighteen months to figure out where it was coming from, and during this time, as my hatred grew, the dreams turned from sex dreams to dreams of carnage. Everything from being shot, stabbed, high speed traffic scares, to a bullet lodged in the brain for two days, so bad that I had to have a tooth pulled out.

Things were happening every day in the newspapers which terrified me, such as Tes De Brinkett being murdered, as I went to primary school with a girl named Brinkett who lived near the golf course in xxxx Crescent. Eventually, I remembered, as a child playing in a drain pipe which ran under the 10th fairway and seeing a trap door open which frightened me and I ran away. This turns out to be an hallucination, and believe me, a nine-year-old shouldn't hallucinate.

I recalled the Wanda Beach Murders, and if you follow the creek past the house where these girls lived, it leads on to the golf links and eventually into a dam on the eleventh hole, next to the 10th fairway.

I went back to the 10th fairway to the drain pipe to see if this trap door was there, and now there is a grate about a meter across like a manhole in the middle of the 10th fairway (on a golf course mind you). I proceeded down the manhole into the drain pipe and noticed there were air vents, other smaller pipes, running from each side of the drain pipe about three quarters of the way up. I didn't find any trap door.

Somewhere around the time, Sydney changed over to natural gas (gas turbines most probably drive this machinery) which doesn't burn as violently, and they could no longer transmit high power things such as heart attacks, and bullets lodged in the brain.

When I got my next dole cheque I bought a sledge hammer and a few other tools. It was a Tuesday, Ladies Day, in October so I went onto the golf links and smashed a reticulation pipe which is for the sprinklers, as I thought this machine may be water cooled. That afternoon was the first I heard of the Stock Market Crash. After a few days they replaced the pipe so I started going back out there at night, smashing another five watering pipes, and chiseling at the dam wall as the entrance to this place may in fact be under the water.

One night a policeman was waiting for me and he told me to lay down on the ground and put his gun in my back. He called on his radio for a police car, and I told him about the air vents in the drain pipe, and when the police car came he uncocked his gun while still holding it in my back. He

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had red hair and they took me to Ryde Police Station and after a short appearance in Court they took me to Long Bay Remand Centre. On the third Court appearance after about three weeks, I managed to escape custody. By now your right I was going insane, but I didn't care whether I lived or died. I managed to get back on the dole and drifted around for a year or so, then went back out to the Golf Links to have another look for this trap door up the other direction from the grate. But when I got down the manhole, down past the air vents the drain pipe had been dammed up to about half way, probably with concrete so I couldn't get down to the air vents, although one air vent is right near the grate. It seems like the red haired policeman had been busy in his spare time.

One night I went back to the Golf Links and dug up 15 of the 18 greens (the other three were lit up near the club house) and it took them a couple of years to arrange the Greenough Axe Murders near Geraldton in WA. Now with Martin Bryant's case I was in Emerald Queensland when it happened. I was working, cotton chipping., with a bloke called Arthur and another called John, who looks exactly like the published photo of Martin Bryant (yes I can produce them).

I've been arrested since escaping, even spending three weeks at Newcastle lock up and Maitland Jail, but no record of my crimes concerning the golf links comes up, even though it made front page news of the Daily Mirror Country Edition, but only about page seven of the Sydney Edition. There is even a horse running around now called West Ryde King. Don't patronize me fellas. These murders are still occurring all over the world, the Rwanda Massacre, the trouble on the West Bank (this machine is located on the West Bank Dam, and the golf course is located between West Ryde and Meadowbank). They even blew up their own space shuttle Challenger. While you're taking another month arguing whether to go and look at this drain pipe, Martin Bryant should be let out on bail. Governments aren't going to admit being involved in this. It's going to be a civilian mob to hold off the police while a couple of Powder Monkeys blow their way in.

This machine can transmit any disease a person has to any other person. Because of the sugar in your body, the nervous system is vibrated on to a frequency something like a quartz crystal in a digital watch which the two GB transmitter carried around the world back to itself to transmit and receive to you. Things like breast cancer, any cancer in fact, Alzheimer's

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disease, multiple sclerosis and they can transmit bad decisions to your doctor or bribe him with sex dreams, but they can't get me.

Figure 62. This document was widely distributed around Australia by the author. It is an example of a systematized delusion. A central component is the belief in an “electronic mind control center located under the 10th fairway at West Ryde Golf Links” and similar mechanisms elsewhere. There is much other psychopathology including FTD and delusions of reference.

Non-systematized delusions

Many delusions are fleeting, being replaced by a series of other delusions. These encountered in schizophrenia (particularly the disorganized form) and mania. (Figure 63)



Figure 63. These items were obtained from a middle aged woman who was suffering acute mania. She had been successful in business. An intimate relationship had recently ended, and there was advice from relatives that her partner had left the relationship with an unjustifiably large amount of money. The patient demonstrated thought disorder, but was able to indicate that she had put money in her vagina. This was retrieved. It was a in the form of a role, about the size of a cigarette. It was secured with rubber

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bands. As the patient was manic it was not surprising that she had used various different brightly colored bands. When the role was opened, it contained \$200. On the wrapping paper was written, "The hole in the Wall". This term is used in some parts of the world to indicate an ATM, from which money is obtained. Some links can be made here: the vagina is a hole, and the intimate partner was believed to have taken some of the patient's money. When the woman recovered her money was returned. There was complete cessation of the delusional thinking which underpinned this behavior.

Obsession and compulsion

Obsessions are persistent, intrusive thoughts. They are usually distressing (such as the thought of killing a loved child) and recognized by the patient as a product of his/her mind and not imposed from outside. The patient attempts to suppress or neutralize these thoughts with other thoughts or actions.

Compulsions are repetitive, intentional behaviors that are performed in response to obsessions. As behaviors, their mention here under content of thought may be questioned. However, there are content of thought issues, with subjective pressure to perform the action, a desire to resist, and the knowledge that the behavior is excessive.

The above textbook description over-simplifies obsessions and compulsions. In clinical practice, the picture is usually complicated. While the connection between the fear of dirt/disease and frequent washing of the hands makes sense, the connection between many obsessions and compulsion is difficult to understand. In other cases a compulsion may exist without an accompanying obsession - an example was a man who had to turn the light on an off three times (irrespective of the time of day or night) when entering a room - he appeared to have no obsession whatsoever (he "just felt more comfortable" when he had performed his ritual).

While the purpose of a compulsion is to reduce the anxiety raised by the obsession, it too may cause distress (there may be a rationale for the compulsion, but it remains a silly, repetitive action which frequently annoys the patient). Thus, both resisting and submitting to both obsessions and compulsions may raise anxiety. And finally, the condition (in the case

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of obsessive-compulsive disorder) changes over time. However, after years of suffering, it may become easier to give in to them than to resist them. That is, resisting these phenomena is anxiety provoking in the early stages, but when the condition is more entrenched and the patient is disabled, with submission the phenomena are less distressing.

True obsessions and compulsions, unaccompanied by other symptoms, are found only in obsessive-compulsive disorder. Obsession and compulsion-like symptoms may accompany other disorders such as schizophrenia and depressive disorder. These remit when the primary disorder abates.

Phobias

A phobia is a persistent, exaggerated and irrational fear of some specific stimulus, associated with a strong desire to avoid that stimulus. Exposure to the stimulus, *in vivo* or imagination, may result in a panic attack.

Agoraphobia

Agoraphobia, in literal terms, means fear of open market spaces. There are many clinical variations. Some authorities conceptualize agoraphobia as the fear of leaving safety - particularly the home. This may lead to the housebound housewife syndrome. For others the important issue may be the fear of being trapped in a place from which escape may be difficult or to which it may be difficult to bring help - this may lead to the avoidance of cramped queues at supermarkets or the chairs in hairdressing salons. There are two forms of agoraphobia - one is associated with panic disorder and the other is not.

In most cases there is avoidance of going out or into feared situations and supportive activity by family or friends.

When recording the disorder, in addition to the provocative issues, it is important to detail the presence or absence of panic, the degree of avoidance and the support provided by friends and relatives.

Social phobia

The essential feature is a persistent fear of one or more social situations in which the person could be scrutinized by others. The patient is concerned

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that he/she may behave in some way that will cause humiliation. The concerns and situations may be specific, such as being unable to continue while public speaking or choking on food while eating, or they may be more general concerns involving most social situations, such as saying something foolish or being unable to continue a conversation. Thus, there may be avoidance of situations such as public speaking and eating in public.

Simple phobia

The essential feature is the persistent fear of a particular stimulus, other than fear of a panic attack (which is included in panic disorder) and fear of certain social situations (which are included in social phobia). Common examples include fear of insects, snakes, height and air travel.

As with other forms of anxiety, phobias may be associated with depressive features.

Hypochondria

Hypochondria is an exaggerated concern regarding one's state of health. It is based not on actual organic pathology, but on inaccurate interpretation of normal physiological events or sensations, which are taken (by the individual) as evidence of physical illness. For example, breathlessness after walking up stairs may be taken as indicating heart disease, transient headache may be taken as indicating brain tumor. By convention, this is not a delusional phenomenon as the patient can be reassured, however, the fear/belief is notoriously persistent as is the consulting of doctors. The distinction from delusion is not always clear and the consulting of doctors approaches acting on a delusion.

Organic disease must be excluded. In hypochondriasis there are longstanding hypochondrical concerns. In some psychotic disorders, anxiety disorders and somatization disorders there may also be hypochondrical concerns which are not long-standing and are a feature of an acute episode. In delusional disorder of somatic type the patient cannot be convinced, even temporarily, that a physical abnormality does not exist.

Suicidal thoughts

Thoughts of suicide range from fleeting ideas in response to stressful events (which may occur in individuals without other psychopathology) through to

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determined, planned and finally executed acts (which are often, but not always, a feature of mental disorder). Social factors and suicidal behavior by influential people in the life of the individual may also be important. (Figure 64.)

The interviewer makes an assessment of the risk of suicide in patients who present claiming suicidal thoughts and those patients who, by the nature of an existing mental disorder, are potentially at risk.

The interviewer should ask about suicidal thoughts, and make clear notes. Such notes are as much for the protection of the clinician as for the patient. The best defense against the charge of negligence is to be able to prove that the time was taken to ask the appropriate questions and consider possibilities.

Generally speaking, at present, Western culture allows direct questions to be asked about suicidal thoughts without giving offence. Nevertheless, with some individuals, more progress may be made if the issue is approached gently. Examples include—‘You’ve got some problems at the moment. Have you ever wanted to escape from them?... How would you do that?... Have you ever thought of injuring yourself in any way?’; ‘Do you ever feel that you deserve punishment?... How would you do that?’; ‘Have you ever thought of ending it all?... What plans have you made?’; ‘I don’t mean to give offence in any way, but I am concerned about you. Some people, faced with these sorts of problems, think about suicide. Have you every thought of that sort of thing?’.

Talk (and the act) of suicide communicates distress. It does not necessarily imply a treatable psychiatric disorder. In individuals with Cluster B personality disorder (especially borderline, histrionic and antisocial type), it may be used as a way of threatening or demanding a particular response, such as admission to hospital, or some other requirement which is difficult to meet. It is known that some individuals with these personality types will die by suicide (some by accident during a suicidal gesture). Some apparently suicidal behavior by overdose arises out of the desire for a period of rest or relief from problems.

Suicide may be a feature of schizophrenia—in which case there may be evidence of recent distress and escalation of delusions, hallucinations and disorganized or bizarre behavior. Suicide may be a feature of depressive

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disorder. In this case it may be preceded by subtle clues - the patient may not begin with thoughts of suicide, but spend time thinking about or missing deceased friends and relatives. Thoughts of guilt or the need for punishment demand action.



Figure 64. Suicidal thinking is difficult to assess. As mentioned above, people with mental disorder die by suicide more frequently than people without mental disorder. Suicidal behavior does not mean a strong intention to die, but it is never possible to be sure about the intentions of another person. In the current authors clinical experience a male patient, in an apparent suicide attempt, drank a container of glycol (potentially fatal; shown on the left). He was treated in Intensive Care and was transferred to the psychiatric ward, where he was found not to have an Axis I disorder, but a personality disorder and many social problems. A week later he went left the hospital and bought two containers of glycol (shown on the right). He drank the entire contents of the smaller container and some of the contents of the larger container. Again, he was treated in Intensive Care and progressed to the psychiatry ward. He was discharged from the ward by a competent psychiatrist (not the current author) without an Axis I disorder, following the resolution of some of his social problems. Such behavior places the patient and the hospital staff in jeopardy (vital in one case and legal in the other).

Homicidal thoughts

Medical defense experts now advise that in some jurisdictions doctors should make a record of having assessed not only suicidal but homicidal thinking in every examination. That has not been the practice of the current

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author, but it may need to become so. Should the clinician become aware of a credible risk to the life or property of an individual, this information should be relayed to that individual and the police. The clinician-patient relationship is privileged, but exceptions are made in respect to the well-being of others.

Homicidal thinking is of two types.

Overt homicidal thinking

Here the patient talks openly of these thoughts

Non-psychotic overt homicidal thoughts

Non-psychotic, here, refers to the thinking process concerning the issue of homicide. A psychotic individual has many thoughts that are not disrupted by the psychosis – for example, psychosis rarely leads to problems with using the toilet. Similarly, it is possible for a person with a psychotic illness to have non-psychotic thoughts about homicide.

Occasionally, an individual presents to a health care professional stating that he/she has the inclination or intends to kill another person. This is usually in a setting of conflict and anger. It may be that the individual wants help with the anger, which can be a subjectively dysphoric experience. Frequently, however, talk of homicide is presented to health care professionals for its manipulative value—to force the health system to provide admission or support, or to play an active part in resolution of a conflict. Depending on the resources and philosophy of the system, such activities may be beyond its role.

In the case of non-psychotic individuals talking of homicide, it is recommended that they be advised that the law will hold them responsible for their actions. This can be delivered in a non-threatening manner—“I can see that you are distressed, but you need to know that your mental will not protect you, and the law will hold you responsible for anything you do’.

Those who are not psychotic and present to health care professionals with overt homicidal thoughts may be normal individuals under unusually severe stress. They are more usually drunk and may manifest a personality disorder. They may be patients whose ability to deal with stress has been reduced by a mental disorder (such people are still held responsible for their actions).

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Psychotic overt homicidal thoughts

Psychotic here refers to the thinking process concerning the issue of homicide.

Psychotic individuals rarely bring themselves to the health care professional with thoughts of homicide as their presenting complaint, but it does happen. More often the patient is brought in by others (police or family) who become aware of this thinking - or the individual presents with other problems and the homicidal thinking is discovered as a co-existing matter in the process of assessment.

Homicidal thoughts may be a feature of schizophrenia or delusional disorder. It will be necessary to take steps to protect the patient and the public.

Covert homicidal thinking

Here the patient does not talk openly about homicidal thoughts.

Non-psychotic covert homicidal thoughts

There is little place for mental health services. If this thinking is discovered the health professional should advise the patient that they will be held responsible for their actions (see above) and discuss the matter with medical defense authorities and/or police (depending on the regional legal system).

Psychotic covert homicidal thoughts

That this thinking is kept secret suggests a level of awareness that the action is against the law and the patient may well - despite the existence of psychosis - therefore, be answerable at law. But this is a complicated area beyond the scope of this book.

Where covert psychotic thinking about homicide exists or is suspected, the health professional should take action to secure the safety of the patient and the public.

Such problems can arise with individuals suffering paranoid illnesses. A huge problem exists with depressed individuals who kill family members in murder-suicide events. Such people may consider the world a terrible place and form the intention to exit via suicide. There may be various justifications

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for murdering family members, perhaps to spare them the terrors of the world, perhaps to conduct them to a better place, perhaps to take them as company.

In such cases the diagnosis of depression may not be apparent and help may not be provided. The best that can be done is to remain alert to the possibility, treat depression energetically, and raise the alarm with family and perhaps police, where risk is considered present. (That is not to contend that all murder-suicide is the result of depressive disorder.)